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SENATE

REPORT
99-112

HANDICAPPED CHILDREN'S PROTECTION ACT OF 1985

JULY 25 (legislative day, JULY 16), 1985.—Ordered to be printed

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 415]

together with

ADDITIONAL VIEWS

The Committee on Labor and Human Resources, to which was referred the bill (S. 415) to amend the Education of the Handicapped Act to authorize the award of reasonable attorneys' fees to certain prevailing parties, and to clarify the effect of the Education of the Handicapped Act on rights, procedures, and remedies under other laws relating to the prohibition of discrimination, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

I. BACKGROUND OF S. 415

In passing the Education of All Handicapped Children Act of 1975 (Public Law 94-142) Congress indicated that "it is in the national interest that the Federal Government assist State and local efforts to provide programs to meet the educational needs of handicapped children in order to assure equal protection of the law." In those States which accept funds under Part B of the Education of the Handicapped Act [EHA], as amended by Public Law 94-142, the act established an enforceable right to a free appropriate public education for all handicapped children and established due process procedures, including the right to judicial review, to protect those rights.

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Congress' original intent was that due process procedures, including the right to litigation if that became necessary, be available to all parents. On July 5, 1984, the Supreme Court, in *Smith* v. *Robinson*, 468 U.S. 2, 104 S. Ct. 3457 (1984), determined that Congress intended that the EHA provide the exclusive source of rights and remedies in special education cases covered by that act. The effect of this decision was to preclude parents from bringing special education cases under section 504 of the Rehabilitation Act of 1973, and recovering attorney's fees available under section 505 of that act, where relief was available under the EHA.

Specifically, in *Smith* v. *Robinson*, the Court ruled that when a remedy "provided under section 504 is provided with more clarity and precision under EHA, a plaintiff may not circumvent or enlarge on the remedies available under EHA by resort to section 504." The Court reasoned that the comprehensiveness and detail with which EHA addresses the provision of special education for handicapped children implies that Congress intended to limit remedies to those explicitly provided for in the EHA.

The situation which has resulted from the *Smith* v. *Robinson* decision was summarized by Justices Brennan, Marshall, and Stevens in their dissenting opinion: "Congress will now have to take the time to revisit the matter." Seeking to clarify the intent of Congress with respect to the educational rights of handicapped children guaranteed by the EHA, the Handicapped Children's Protection Act of 1985 was introduced on February 6, 1985. The Subcommittee on the Handicapped held a hearing on May 16, 1985, to receive testimony from parents of handicapped children, attorneys who have represented parents of handicapped children in EHA litigation (including the *Smith* v. *Robinson* case), and Edwin Martin, former Assistant Secretary of Education for Special Education and Rehabilitative Services. Written testimony was also received from the National School Boards Association and various parent, advocacy, and professional education groups. On June 11, 1985, the Subcommittee unanimously reported S. 415 with amendment to the full Committee. On July 10, 1985, the full Committee unanimously moved to order the bill, as amended, reported to the Senate.

II. Section-by-Section Analysis

S. 415 as reported by the full Committee consists of six sections. Throughout the remainder of this report the word "school" should be interpreted to include State or local educational agencies or intermediate educational units, as appropriate; the phase "parent or legal representative" includes a person acting as a parent of a child or a surrogate parent who has been appointed in accordance with section 615(b)(1) of the EHA; and the words "reasonable attorney's fees" simply mean fees appropriate in the circumstances of each case as determined by court.

Section 1 provides that this Act be cited as the Handicapped Children's Protection Act of 1985.

Section 2 provides for the award of reasonable attorney's fees to prevailing parents in EHA civil actions and in administrative proceedings to parents in certain specified circumstances.

Section 3 provides that the court cases will be heard de novo if attorneys are not used at the due process hearing level.

Section 4 provides that the EHA does not limit the applicability of other laws which protect handicapped children and youth, except that when a parent brings suit under another law when that suit could have been brought under the EHA, the parent will be required to exhaust EHA administrative remedies to the same degree as would have been required had the suit been brought under the EHA.

Section 5 authorizes parent training centers under section 631 of the EHA to train parents better to understand and participate in due process proceedings and requires the establishment of at least one parent training center in each State.

Section 6 established a general effective date as the date of enactment and also authorizes courts retroactively to award attorney's fees for civil court actions to parents who prevailed in EHA cases pending on or brought after the date of the *Smith* v. *Robinson* decision.

III. Budget Estimate

On July 17, 1985, the Congressional Budget Office sent the following letter to the Chairman, which concludes that S. 415, as reported, would result in no increase in Federal costs.

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 17, 1985.

Hon. Orrin G. Hatch,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has examined the federal cost impact of S. 415, the Handicapped Children's Protection Act of 1985, as ordered reported from the Senate Committee on Labor and Human Resources, July 10, 1985. This bill amends the Education of All Handicapped Children Act, (EAHCA) to allow for the award of reasonable attorneys' fees to certain prevailing parties in law suits and to clarify the effect of the EAHCA on rights, procedures, and remedies under other laws relating to the prohibition of discrimination.

Based on our analysis, there would be no increase in federal costs as a result of this bill. S. 415, however, could affect the budgets of state and local governments. EAHCA (Public Law 94-142) requires local public school districts in the United States to provide a free and appropriate public education to all handicapped children in the school district. This bill would authorize the award of reasonable attorneys' fees to prevailing parties that successfully litigate cases under the amended EAHCA. In the past, successfully litigated cases under the EAHCA had relied on the authority of other laws in awarding attorneys' fees. The Supreme Court recently ruled, however, in Smith v. Robinson that the EAHCA remedies may not be enlarged to include items such as attorneys' fees by resorting to other laws. If cases are successfully litigated under the amended EAHCA against a state or local education authority, then that authority could be responsible for paying the attorneys' fees.

Historically, there have been 42 successfully litigated cases under EAHCA of which 23 involved claims. Of those cases, 15 had been awarded attorneys' fees ranging from $2,000 to $212,000 depending on the type and scope of the case.

Please call me if you have any questions or have your staff contact Deborah Kalcevic (226-2820).

With best wishes,

Sincerely,

ERIC HANUSHEK
(for Rudolph G. Penner).

IV. TABULATION OF VOTES CAST IN COMMITTEE

The motion to report the bill favorably to the Senate was passed unanimously by voice of the Committee. An earlier motion to strike the provision placing conditions upon fee awards for publicly funded attorneys who represent prevailing parents in EHA cases was defeated by a vote of 9 to 7.

V. REGULATORY IMPACT STATEMENT

The Committee has determined that there will be minimal increase in regulatory burden imposed by this bill. While new regulations will need to be promulgated to reflect the new provisions in the bill, those regulations build on existing regulations.

VI. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standard Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

EDUCATION OF THE HANDICAPPED ACT

* * * * * * *

PROCEDURAL SAFEGUARDS

SEC. 615. (a) Any State educational agency, any local educational agency, and any intermediate educational unit which receives assistance under this part shall establish and maintain procedures in accordance with subsection (b) through subsection (e) of this section to assure that handicapped children and their parents or guardians are guaranteed procedural safeguards with respect to the provision of free public education by such agencies and units.

(b)(1) The procedures required by this section shall include, but shall not be limited to—

(A) an opportunity for the parents or guardian of a handcapped child to examine all relevant records with respect to the indentification, evaluation, and educational placement of the child and the provision of a free appropriate public education to such child and to obtain an independent educational evaluation of the child;

(B) procedures to protect the rights of the child whenever the parents or guardian of the child are not known, unavailable, or the child is a ward of the State, including the assignment of an individual (who shall not be an employee of the State educational agency, local educational agency, or intermediate educational unit involved in the education or care of the child) to act as a surrogate for the parents or guardian;

(C) written prior notice to the parents or guardian of the child whenever such agency or unit—

(i) proposes to initiate or change, or

(ii) refuses to initiate or change,

the identification, evaluation, or educational placement of the child or the provision of a free appropriate public education to the child;

(D) procedures designed to assure that the notice required by clause (C) fully inform the parents or guardian, in the parents' or guardian's native language, unless is not feasible to do so, of all procedures available pursuant to this section; and

(E) an opportunity to present complaints with respect to any matter relating to the identification, evaluation, or educational placement of the child, or the provision of a free appropriate public education to such child.

(2)*(A)* Whenever a complaint has been received under paragraph (1) of this subsection, the parents or guardian shall have an opportunity for an impartial due process hearing which shall be conducted by the State educational agency or by the local educational agency or intermediate educational unit, as determined by State law or by the State educational agency. No hearing conducted pursuant to the requirements of this paragraph shall be conducted by an employee of such agency or unit involved in the education or care of the child.

(B) Within 5 days, after the receipt of a complaint under paragraph (1), the State or local educational agency or intermediate educational unit shall notify the parent or legal representative of the handicapped child or youth whether or not the State of local educational agency or intermediate educational unit, as the case may be, will use the services of an attorney in conjunction with the impartial due process hearing under this subsection, or the impartial review under subsection (c), in the manner described in section 615A(b)(1).

(c) If the hearing required in paragraph (2) of subsection (b) of this section is conducted by a local educational agency or an intermediate educational unit, any party aggrieved by the findings and decision rendered in such a hearing may appeal to the State educational agency which shall conduct an impartial review of such hearing. The officer conducting such review shall make an independent decision upon completion of such review.

(d) Any party to any hearing conducted pursuant to subsections (b) and (c) shall be accorded (1) the right to be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of handicapped children, (2) the right to present evidence and confront, cross-examine, and compel the attendance of witnesses, (3) the right to a written or electronic verbatim record of such hearing, and (4) the right to

written findings of fact and decisions (which findings and decisions shall also be transmitted to the advisory panel established pursuant to section 613(a)(12)).

(e)(1) A decision made in a hearing conducted pursuant to paragraph (2) of subsection (b) shall be final, except that any party involved in such hearing may appeal such decision under the provisions of subbsection (c) and paragraph (2) of this subsection. A decision made under subsection (c) shall be final except that any party may bring an action under paragraph (2) of this subsection.

(2)*(A)* Any party aggrieved by the findings and decision made under subsection (b) who does not have the right to an appeal under subsection (c), and any party aggrieved by the findings and decision under subsection (c), shall have the rights to bring a civil action with respect to the complaint presented pursuant to this section, which action may be brought in any State court of competent jurisdiction or in a district court of the United States without regard to the amount in controversy. [In] *Except as provided in subparagraph (B), in* any action brought under this paragraph the court shall receive the records of the administrative proceedings, shall hear additional evidence at the request of a party and, basing its decision on the preponderance of the evidence, shall grant such relief as the court determines is appropriate.

(B) In any action brought under this paragraph in which no attorney participated in the hearing under subsection (b) or in review under subsection (c), the court shall hear the case de novo, but the trial de novo may not include the introduction of unrelated issues which the court determines would circumvent the exhaustion of administrative remedies.

(3) During the pendency of any proceedings conducted pursuant to this section, unless the State or local educational agency and the parents or guardian otherwise agree, the child shall remain in the then current educational placement of such child, or, if applying for initial admission to a public school, shall, with the consent of the parents or guardian be place in the public school program until all such proceedings have been completed.

(4) The district courts of the United States shall have jurisdiction of actions brought under this subsection without regard to the amount of controversy.

(f) The provisions of section 615A shall govern the award of a reasonably attorney's fee, reasonable witness fees, and other reasonable expenses in connection with any impartial due process hearing under subsection (b) of this section, any impartial review under subsection (c), and the bringing of the civil action under subsection (e).

(g) Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under the Constitution, title V of the Rehabilitation Act of 1973, or other Federal statutes protecting the rights of handicapped children and youth, except that before the filing of a civil action under such laws seeking relief that is also available under this part, the procedures under subsections (b)(2) and (c) shall be exhausted to the same extent as would be required had the action been brought under this part.

FEES AND EXPENSES

SEC. 615A. (a)(1)(A) Except as provided in subparagraphs (B) and (C), in any civil action brought under section 615(e), the court may, in its discretion, award a reasonable attorney's fee, reasonable witness fees, and other reasonable expenses of the civil action, in addition to the costs to a parent or legal representative of a handicapped child or youth who is the prevailing party.

(B) Whenever—

(i) the decision of the impartial due process hearing under section 615(b) or the impartial review of such hearing under section 615(c) is in favor of the parent or legal representative of a handicapped child or youth, and

(ii) the State or local educational agency or intermediate educational unit appeals the decision pursuant to section 615(e),

the parent or legal representative of the handicapped child or youth shall be awarded a reaonable attorney's fee, reasonable witness fees, and other reasonable expenses of the civil action.

(C) Whenever—

(1) the decision of the impartial due process hearing under section 615(b) or the impartial review of such hearing under section 615(c), and the decision of the court, is in favor of the parent or legal representative of a handicapped child or youth, and

(ii) the State of local educational agency or intermediate educational unit appeals the decision of the court pursuant to section 615(e),

the parent or legal representative of the handicapped child or youth shall be awarded a reasonable attorney's fees, reasonable witness fees, and other reasonable expenses of such appeal.

(2) Whenever the parent or legal representative—

(A) is awarded fees under subparagraph (A), (B), or (C), and

(B) is represented by a publicly funded organization which provides legal services,

the reasonable attorney's fee which is awarded pursuant to this subsection shall be computed based upon the actual cost related to the bringing of the civil action under section 615(e) to the publicly funded organization, including the proportion of the compensation of the attorney so related, other reasonable expenses which can be documented, and the proportion of the annual overhead costs of the publicly funded organization attributable to the number of hours reasonable spent on such civil action.

(b)(1) If the State or local educational agency, or intermediate educational unit, determines, after the receipt of a complaint under section 615(b)(1), to use the services of an attorney in conjunction with the impartial due process hearing under section 615(b)(2), or the impartial review under section 615(c), for consultation, preparation, presentation of written or oral argument, or evidence, then the State or local educational agency or intermediate educational unit, as the case may be, shall—

(A) notify the parent or legal representative of the handicapped child or youth of its intention to use an attorney in the manner described in this subsection as required by section 615(b)(2)(B);

(B) furnish to the parent or legal representative of such a child or youth a list of attorneys who practice in the area in which the handicapped child or youth resides, and who are knowledgeable about special education law, regulations, and procedures; and

(C) pay the costs of the State or local education agency or intermediate educational unit, as the case may be, and the costs of the parent or legal representative of the handicapped child or youth, for reasonable attorneys' fees, reasonable witness fees, and other reasonable expenses related to the hearing or review, as the case may be.

(2) If the parent or legal representative of the handicapped child or youth determines—

(A) after filing a complaint under section 615(b)(2) and after receiving notification from the State or local educational agency or intermediate educational unit under section 615(b)(2)(B) that the State or local educational agency or intermediate educational unit will not use an attorney; or

(B) after the filing of a complaint under section 615(b)(2) and prior to the notification of the State or local educational agency or intermediate educational unit under section 615(b)(2)(B),

to use the services of an attorney in conjunction with the impartial due process hearing under section 615(b)(2), or the impartial review under section 615(b)(c), for consultation, preparation, presentation of written or oral argument or evidence, then—

(i) the parent or legal representative shall notify the State, local educational agency, or intermediate educational unit, as the case may be, within 5 days after receipt of the notification of such agency or unit under section 615(b)(2)(B) of their intention to use an attorney in the manner described in this subsection;

(ii) the parent or legal representative of the handicapped child or youth shall pay the cost of attorneys' fees, witness fees, and other expenses relating to the hearing or review, as the case may be, incurred by such parent or legal representative; and

(iii) the State or local educational agency or intermediate educational unit shall pay the cost of attorneys' fees, witness fees, and other expenses incurred by the State or local educational agency or intermediate educational unit, as the case may be.

(3) If the State or local educational agency or intermediate educational unit determines not to use the services of an attorney in conjunction with the due process hearing under section 615(b)(2), or the impartial hearing review under section 615(c), in the manner described in paragraph (1), the State or local educational agency or intermediate educational unit, as the case may be, shall—

(A) notify the parent or legal representative of the handicapped child or youth as required by section 615(b)(2)(B); and

(B) furnish to the parent or legal representative of such child or youth a list of parent training centers, Protection and Advocacy Agencies, and other organizations, which are located in the area in which the handicapped child or youth resides, and

which are knowledgeable about special education law, regulations, and procedures.

* * * * * * *

PART D—TRAINING PERSONNEL FOR THE EDUCATION OF THE HANDICAPPED

GRANTS FOR PERSONNEL TRAINING

SEC. 631. (a)(1) The Secretary is authorized to make grants, which may include scholarships with necessary stipends and allowances, to institutions of higher education (including the university-affiliated facilities program under the Rehabilitation Act of 1973 and the satellite network of the developmental disabilities program) and other appropriate nonprofit agencies to assist them in training personnel for careers in special education including—

(A) special education teaching, including speech, language, and hearing impaired, and adaptive physical education;

(B) related services to handicapped children and youth in educational settings;

(C) special education supervision and administration;

(D) special education research; and

(E) training of special education personnel and other personnel providing special services.

(2) The Secretary shall ensure that grants awarded to applicant institutions and agencies under this subsection meet State and professionally recognized standards for the training of special education and related services personnel.

(3) Grants under this subsection may be used by such institutions to assist in covering the cost of courses of training or study for such personnel and for establishing and maintaining fellowships or traineeships with such stipends and allowances as may be determined by the Secretary.

(4) The Secretary in carrying out the purposes of this subsection may reserve a sum not to exceed 5 per centum of the amount available for this subsection in each fiscal year for contracts to prepare personnel in areas where shortages exists, when a response to that need has not been adequately addressed by the grant process.

(b) The Secretary is authorized to make grants to institutions of higher education and other appropriate nonprofit agencies to conduct special projects to develop and demonstrate new approaches for the preservice training purposes set forth in subsection (a), for regular educators, and for the inservice training of special education personnel, including classroom aides, related services personnel, and regular education personnel who serve handicapped children.

(c)(1) The Secretary is authorized to make grants through a separate competition to private nonprofit organizations for the purpose of providing training and information to parents of handicapped children and [volunteers] *other individuals* who work with parents to enable such individuals to participate more effectively with professionals in meeting the educational needs of handicapped children. Such grants shall be designed to meet the unique training and information needs of parents of handicapped children, includ-

ing those who are members of groups that have been traditionally underrepresented, living in the area to be served by the grant.

(2) In order to receive a grant under this subsection a private nonprofit organization shall—

(A) be governed by a board of directors on which a majority of the members are parents of handicapped children and which includes members who are professionals in the field of special education and related services who serve handicapped children and youth; or if the nonprofit private organization does not have such a board, such organization shall have a membership which represents the interests of individuals with handicapping conditions, and shall establish a special governing committee on which a majority of the members are parents of handicapped children and which includes members who are professionals in the fields of special education and related services, to operate the training and information program under this subsection;

(B) serve the parents of children with the full range of handicapping conditions under such grant program; and

(C) demonstrate the capacity and expertise to conduct effectively the training and information activities authorized under this subsection.

(3) The board of directors or special governing committee of a private nonprofit organization receiving a grant under this subsection shall meet at least once in each calendar quarter to review such parent training and information activities, and each such committee shall advise the governing board directly of its views and recommendations. Whenever a private nonprofit organization requests the renewal of a grant under this subsection, the board of directors or the special governing committee shall submit to the Secretary a written review of the parent training and information program conducted by that private nonprofit organization during the preceding fiscal year.

(4) The Secretary shall ensure that grants under this subsection will—

(A) be distributed geographically [to the greatest extent possible throughout all the States] *with at least one grant made in each State*; and

(B) be targeted to parents of handicapped children in both urban and rural areas, or on a State, or regional basis.

(5) Parent training and information programs assisted under the subsection shall assist parents to—

(A) better understand the nature and needs of the handicapping conditions of their child;

(B) provide followup support for their handicapped child's educational programs;

(C) communicate more effectively with special and regular educators, administrators, related services personnel, and other relevant professionals;

(D) participate in educational decisionmaking processes including the development of their handicapped child's individualized educational program;

(E) obtain information about the programs, services, and resources available to their handicapped child, and the degree to

which the programs, services, and resources are appropriate; [and]

(F) understand the administrative procedures available under section 615 and effectively participate, if parents wish to, in the due process hearing and impartial review authorized by such section; and

[(F)] *(G)* understand the provisions for the education of handicapped children as specified under part B of this Act.

(6) Each private nonprofit organization operating a program receiving assistance under this subsection shall consult with appropriate agencies which serve or assist handicapped children and youth and are located in the jurisdictions served by the program.

(7) The Secretary shall provide technical assistance, by grant or contract, for establishing, developing, and coordinating parent training and information programs.

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VII. ADDITIONAL VIEWS OF SENATORS HATCH, WEICKER, STAFFORD, DOLE, PELL, MATSUNAGA, SIMON, KERRY, KENNEDY, METZENBAUM, DODD, AND GRASSLEY

While the full committee (at the markup of July 10, 1985) voted unanimously to report S. 415 as amended, there were numerous expressions of concern that further work would need to be done prior to Senate consideration of the bill.

As a result, Senator Hatch, as chairman of the full committee, and Senator Weicker, as chairman of the Subcommittee on the Handicapped, met with representatives of the administration and other interested parties, and, with the agreement of the Department of Education decided to offer an amendment in the form of a substitute when S. 415 is considered on the Senate floor. This amended version of S. 415 is considered by Senators Stafford, Dole, Pell, Matsunaga, Simon, Kerry, Kennedy, Metzenbaum, Dodd, and Grassley.

Throughout the remainder of this section of the report the word "school" should be interpreted to include State or local educational agencies or intermediate educational units, as appropriate; the phrase "parent or legal representative" includes a person acting as a parent of a child or a surrogate parent who has been appointed in accordance with section 615(b)(1)(B) of the EHA; and the words "reasonable attorney's fees" simply mean fees appropriate in the circumstances of each case as determined by the Court.

SECTION-BY-SECTION ANALYSIS OF PROPOSED AMENDMENT

The bill described below, which will be offered as an amendment in the nature of a substitute to S. 415 on the Senate floor, is similar to the original version of S. 415, introduced on February 6, 1985, with two substantive additions. A section-by-section analysis of the substitute amendment to be offered on the Senate floor follows.

Section 1 provides that this Act may be known as the Handicapped Children's Protection Act of 1985.

Section 2 provides the award of reasonable attorney fees to prevailing parents in an EHA action or proceeding. In those cases where the prevailing parent is represented by an attorney who is employed by an organization which receives its operating expenses from Federal, State, or local governmental sources for the purpose of providing legal services, the organization shall be compensated based on the organization's costs.

Section 3 provides that the EHA does not limit the applicability of other laws which protect handicapped children and youth, except that when a parent brings suit under another law when that suit could have been brought under the EHA, the parent will be required to exhaust EHA administrative remedies to the same degree

as would have been required had the suit been brought under the EHA.

Section 4 authorizes courts to award attorney's fees in conjunction with any EHA action or proceeding brought after July 3, 1984, or brought before July 4, 1984, but still pending on July 4, 1984. This provision would thus apply to cases brought on or pending on the date of the *Smith* v. *Robinson* decision.

DISCUSSION OF SUBSTITUTE BILL

GENERAL

The Committee believes that the substitute bill provides fee awards to handicapped children on a basis similar to other fee shifting statutes when securing the rights guaranteed to them by the EHA.

AWARD OF FEES AND EXPENSES

Section 2 of the bill amends section 615(e)(4) of the EHA to permit a court, in its discretion, to award reasonable attorney's fees to parents or legal representatives of a handicapped child or youth who is the prevailing party in any action or proceeding brought under this subsection.

It is the committee's intention that a parent or legal representative should be free to select and be represented by the attorney of his/her choice.

The committee understands and intends that State and local agencies may not use funds made available to them under part B of the EHA to pay attorney's fees or other costs incurred by parents that a court assesses against those agencies under the bill. Using these funds for those costs would divert scarce resources from direct services to handicapped children.

It is the committee's intent that the terms "prevailing party" and "reasonable" be construed consistent with the U.S. Supreme Court's decision in *Hensley* v. *Eckerhart,* 461 U.S. 424, 440 (1983). In this case, the Court held that:

> the extent of a plaintiff's success is a crucial factor in determining the proper amount of an award of attorney's fees. Where the plaintiff has failed to prevail on a claim that is distinct in all respects from his successful claims, the hours spent on the unsuccessful claim should be excluded in considering the amount of a reasonable fee. Where a lawsuit consists of related claims, a plaintiff who has won substantial relief should not have his attorney's fee reduced simply because the district court did not adopt each contention raised. But where the plaintiff achieved only limited success, the district court should award only that amount of fees that is reasonable in relation to the results obtained.

It is also the committee's intent that, consistent with section 300.10 of Title 34 of the Code of Federal Regulations (EHA regulations) the term "parent or legal representative" includes a person acting as a parent of a child or a surrogate parent who has been appointed in accordance with section 615(b)(1)(B) of the EHA. The

term does not include the State if the child is a ward of the State. Under appropriate circumstances, a child or youth may also bring an action under the EHA and receive an award of attorney's fees to the extent that he/she prevails.

The committee also intends that section 2 should be interpreted consistent with fee provisions of statutes such as title VII of the Civil Rights Act of 1964 which authorizes courts to award fees for time spent by counsel in mandatory administrative proceedings under those statutes. See *New York Gaslight Club, Inc.* v. *Carey,* 447 U.S. 54 (1980), (compare *Webb* v. *Board of Education for Dyer County,* 53 U.S.L.W. 4473 (U.S. April 17, 1985) in which the court declined to award fees for work done at the administrative level because the statute under which the suit was brought did not require the exhaustion of administrative remedies prior to going to court).

The committee intends that S. 415 will allow the Court, but not the hearing officer, to award fees for time spent by counsel in mandatory EHA administrative proceedings. This is consistent with the committee's position that handicapped children should be provided fee awards on a basis similar to other fee shifting statutes when securing the rights guaranteed to them by the EHA.

It is the intention of the committee to adopt the policy of *Christianburg Garment Co.* v. *EEOC,* 434 U.S. 412 (1978), which is that a party which brings an action that is "frivolous, unreasonable, or without foundation" may be held liable for the prevailing defendant's attorney fees. Nothing in S. 415 should override this established principle concerning frivolous lawsuits. While the committee has no evidence that parents bring EHA suits which are frivolous, unreasonable, or without foundation, in the rare instance where this occurs, this provision would apply.

The committee included subsection (c) to ensure that in those cases where the prevailing party is represented by an attorney who is employed by an organization which receives funds, other than attorney fees awards, from Federal, State, or local governmental sources, the party should be awarded fees on the basis of the actual costs of the litigation to the organization. This limits "double-dipping" or providing attorney fee awards out of governmental funds to organizations already receiving some funding from governmental sources. Several courts have already addressed this concern by awarding fees on the basis of the hourly wages of the organizational attorneys involved plus the percentage of the annual overhead attributable to the number of hours reasonably spent on such actions. See, e.g., *NYSARC* v. *Carey,* 711 F. 2d 1136 (2d Cir 1983); *Alsager* v. *District Court,* 447 F. Supp. 572 (S.D. Iowa 1977); *Page* v. *Preisser,* 468 F. Supp. 399 (S.D. Iowa 1979). For purposes of this limitation, "publicly funded organization" means any organization which receives funds, other than attorney fee awards, from governmental sources, which funds are available at any time during the year in which the action or administrative proceeding is pending to enable the organization to provide legal counsel or representation.

The committee reaffirms that more information about the frequency and nature of due process hearings and EHA court actions would be helpful to legislators and program administrators. Consequently, it is the desire of the committee that information about

the findings and decisions of due process hearings shall be made available to the public consistent with section 617(c) of the EHA.

EFFECT ON OTHER LAWS

Although section 3 of the bill provides that the EHA does not affect the applicability of other Federal laws related to special education, it also makes clear that nothing is S. 415 should be interpreted to allow parents to circumvent the due process procedures and protections created under the EHA. For example, under the EHA parents must generally exhaust administrative remedies to attempt to resolve certain disagreements before filing a civil court action. Section 3 makes it clear that when parents choose to file suit under another law that protects the rights of handicapped children (e.g., section 504 of the Rehabilitation Act), if that suit could have been filed under the EHA, then parents are required to exhaust EHA administrative remedies to the same extent as would have been necessary if the suit had been filed under the EHA. Exhaustion of EHA administrative remedies would thus be excused where they would not be required to be exhausted under the EHA, such as when resort to those proceedings would be futile.

The committee also wishes to make it clear that nothing in the Bill effects standards traditionally used by courts under the EHA and other statutes for determining when class action suits may be maintained, or when particular remedies, such as injunctive relief may be granted.

EFFECTIVE DATE OF ENACTMENT

The bill would be effective on enactment. However, the bill also provides that parents who filed after *Smith* v. *Robinson* or whose action or proceeding was pending at the time of *Smith* v. *Robinson* may be awarded fees on the same grounds as parents whose action or proceeding is brought after the enactment of S. 415.

TEXT OF AMENDMENT PROPOSED TO BE SUBSTITUTED FOR COMMITTEE REPORTED VERSION OF S. 415

S. 415

To amend the Education of the Handicapped Act to authorize the award of reasonable attorneys' fees to certain prevailing parties, and to clarify the effect of the Education of the Handicapped Act on rights, procedures, and remedies under other laws relating to the prohibition of discrimination.

In lieu of the matter proposed to be inserted by the committee amendment insert the following:

That this Act may be cited as the "Handicapped Children's Protection Act of 1985".

SEC. 2. Section 615(e)(4) of the Education of the Handicapped Act is amended by inserting "(A)" after the paragraph designation and by adding at the end thereof the following new subparagraphs:

"(B) In any action or proceeding brought under this subsection, the court, in its discretion, may award a reasonable attorney's fee in addition to the costs to a parent or legal representative of a handicapped child or youth who is the prevailing party.

"(C) Whenever the parent or legal representative of a handicapped child or youth—

"(i) is awarded fees under subparagraph (B), and

"(ii) is represented by a publicly funded organization which provides legal services,

the reasonable attorney's fee which is awarded pursuant to this subsection shall be computed based upon the actual cost related to the bringing of the civil action under this subsection to the publicly funded organization, including the proportion of the compensation of the attorney so related, other reasonable expenses which can be documented, and the proportion of the annual overhead costs of the publicly funded organization attributable to the number of hours reasonably spent on such civil action.

"(D) For the purpose of this paragraph, the term 'publicly funded organization' means any organization which receives funds, other than attorney fee awards, from Federal, State, or local governmental sources which are available for use during any fiscal year in which the action or proceeding is pending to enable the organization to provide legal counsel or representation.".

SEC. 3. Section 615 of the Education of the Handicapped Act is amended by adding at the end thereof the following new subsection:

"(f) Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under the Constitution, title V of the Rehabilitation Act of 1973, or other Federal statutes protecting the rights of handicapped children and youth, except that before the filing of a civil action under such laws seeking relief that is also available under this part, the procedures under subsections (b)(2) and (c) shall be exhausted to the same extent as would be required had the action been brought under this part.".

SEC. 4. The amendment made by section 2 shall apply with respect to actions or proceedings brought under section 615(e) of the Education of the Handicapped Act after July 3, 1984, and actions or proceedings brought prior to July 4, 1984, under such section which were pending on July 4, 1984.

VIII. ADDITIONAL VIEWS OF KERRY, KENNEDY, PELL, DODD, SIMON, METZENBAUM, AND MATSUNAGA

Although strongly endorsing the principle that parents or legal representatives of handicapped children must be able to access the full range of available remedies in order to protect their handicapped children's educational rights, seven members of the committee (Kerry, Kennedy, Pell, Dodd, Simon, Metzenbaum, and Matsunaga) believe that one provision should be deleted from the legislation. Language exists in the bill which limits attorney's fees available to nonprofit, publicly funded organizations who provide legal assistance, yet will not limit fees to privately funded attorneys. Undoubtedly, this creates a blatant double standard which will have a particularly negative impact on lower income handicapped children most dependent on legal representation by publicly funded attorneys. Furthermore, by requiring that attorneys' fees awarded to publicly funded attorneys be computed according the cost-based standard rather than the prevailing market-based standard used by private attorneys, a dangerous precedent for all future cases litigated in this area will be set.

We would like to note last year's U.S. Supreme Court decision, *Blum* v. *Stenson,* where the Court ruled unanimously that under the Civil Rights Attorney Act of 1976, all attorney's fees (including publicly funded atorneys' fees), must be calculated according to prevailing market rates. Before congressional intent is created through passage of this provision regarding lower attorneys' fees award in cases brought to court on behalf of the educational rights of handicapped children, Congress should have the opportunity to closely examine this important issue. It is our belief that after extensive study of this precedent setting issue, Congress will preserve the standards upheld in the *Blum* v. *Stenson* decision.

In addition, it should be noted that money awarded to publicly funded attorneys is recycled back into the organization for which the attorney works to expand services to low income individuals. Under our present system, offices which provide legal assistance to indigent handicapped children encounter an overwhelming demand for their services, and unfortunately have very limited resources to meet this demand. It is our feeling that any additional funds made available to expand legal services to our Nation's disabled poor citizens, is money well spent.

Further, the cap on publicly funded attorneys' fees would deter schools from settling cases expeditiously. Schools not faced with having to pay more substantial attorneys' fees at the fair market rate will have an incentive to draw judicial proceedings out in an attempt to force plaintiffs to abandon their cases. The testimony by Mary L. Tatro before the Subcommittee on the Handicapped last May, portrays a clear example of school district extending judicial proceedings for more than 5 years in an attempt to force the Tatro

family to drop their case due to exorbitant costs of attorneys' fees. The Tatro's legal fees exceeded $200,000. If it were not for the assistance of a public advocacy group willing to take their case, they would have been forced to abandon their daughter, Amber's cause and thus give up the right of Amber to attend school and receive a decent education.

Because the substitute amendment to be offered on the floor is designed to reinforce the rights to education for all handicapped children provided under Public Law 94-142, the Education of the Handicapped Act, including their essential rights to access the courts when education is being denied to them, we have decided to cosponsor the amendment. However, by limiting the attorneys' fees to those who represent handicapped children who are poor, we are ultimately limiting the rights to an appropriate education for less fortunate handicapped children in this country. Consequently, we believe that by maintaining this provision in the bill, an unfair double standard will be set.

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SENATE

REPORT
99-117

PUBLIC HEALTH SERVICE ACT MEDICAL AMENDMENTS OF 1985

JULY 26 (legislative day JULY 16), 1985.—Ordered to be printed

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 1210]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1210), to amend the Public Health Service Act to authorize the Secretary of Health and Human Services to establish a registry of teaching hospitals, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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I. OVERVIEW AND SUMMARY

On January 31, 1985, Senator Quayle published a proposal to reform graduate medical education (GME) in the *Congressional Record.*

Graduate medical education (also known as residency training) refers to the training that a physician receives after graduation from medical school but before entry into practice. Generally, these

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are hospital based programs in which the physician specializes in clinical "hands-on" training in a specific area such as internal medicine, general surgery, etc. Almost all the states require such training before a physician can be licensed to practice.

On March 25, 1985, the Senate Subcommittee on Employment and Productivity held a hearing on this proposal. Significant modifications were made to the proposal and on May 23, 1985, Senators Quayle and Hatch introduced S. 1210, "The Public Health Service Act Medical Education Amendments of 1985".

On June 13, 1985, the Subcommittee on Employment and Productivity reported S. 1210, without amendments, to the full Senate Labor and Human Resources Committee (hereonafter referred to as the Committee) by a vote of 6-1.

On July 10, 1985, the Committee on Labor and Human Resources Committee conducted an executive session on S. 1210 during which Senators Quayle, Hatch and Kennedy offered an amendment in the nature of a substitute to S. 1210. This amendment was uanimously adopted by a roll call vote of 16-0 and the bill was reported out of the Committee.

As reported, the bill provides a mechanism by which national physician manpower goals can be developed and establishes a voluntary process by which medical education institutions can work to achieve these goals. The bill is directed at addressing physician manpower problems of oversupply and overspecialization. S. 1210 is designed to: (1) encourage a shift in the distribution of graduate medical education positions from the medical and surgical specialties and subspecialties to the primary care specialties; and (2) limit the number of positions that can be filled by graduates of foreign medical schools.

The development of this legislation was prompted by a consensus that: (1) this country will have an excess supply of physicians by 1990 and that the specialty distribution of these physicians will not be consistent with the country's needs; and (2) steps need to be taken to address the problem of the high number of U.S. citizens who, unable to achieve admission to U.S. medical schools, attend foreign medical schools of inferior quality and later return to this country to receive the graduate medical education necessary for licensure and certification.

Summary of Bill

The Public Health Service Act Medical Education Amendments of 1985 establishes a mechanism to set explicit physician manpower goals and a process by which teaching hospitals and medical schools can work voluntarily with the Federal government to achieve these goals. This legislation addresses two manpower issues—the oversupply and specialty maldistribution of physicians—by focusing on the relationship between the current system of graduate medical education and the perpetuation of these manpower problems.

The bill is designed to prevent arbitrary disruptions in graduate medical education programs. The 42 month time frame for the bill allows ample time for schools, hospitals, and medical students to plan accordingly.

Teaching Hospital Registry

The Public Health Service Act Medical Education Amendments of 1985 requires the Secretary of Health and Human Services to establish a registry for teaching hospitals which provide assurances to the Secretary that the hospital will comply with the primary care and foreign medical graduate provisions of the bill.

In order to register, hospitals would have to agree to designate a minimum percentage of their residency positions in the primary care specialties for its class of hospital. A hospital can comply with this requirement individually or as part of a group of hospitals. Additionally, at least 75% of the residents in each of a hospital's graduate medical education programs would have to be graduates of schools of medicine accredited by the Liaison Committee on Medical Education (L.C.M.E.) or schools of osteopathy accredited by the American Osteopathic Association through its Committee on Postdoctoral Training.

Establishment of Minimum Percentages for Primary Care Specialty Positions

The bill requires, within one year of enactment, that the Council on Graduate Medical Education (established under this bill) make recommendations to the Secretary with respect to the establishment of national targets for residency positions in the primary care specialties for a four year period. To achieve the national targets, the Council must make recommendations to the Secretary for the establishment of different minimum percentages for different classes of hospitals, based on the graduate medical education programs of such hospitals in Fiscal Year 1985 and such other criteria as the Secretary deems relevant.

Within six months after receiving recommendations from the Council, the Secretary shall by regulation either establish the minimum percentages recommended by the Council for a four year fiscal period or remand such recommendations to the Council.

The minimum percentages established by the Secretary may not be effective later than 24 months after the Secretary establishes such percentages.

The Council shall submit such recommendations to the Secretary every four fiscal years and within six months of receipt the Secretary must establish these by regulation or remand the recommendations to the Council.

The bill defines primary care specialties as the medical specialties of internal medicine, pediatrics, family practice, or any other medical specialty determined by the Secretary after consultation with the Council.

For the purpose of determining whether a hospital or a group of hospitals has complied with the applicable minimum percentage, the following types of positions are positions in primary care specialties: (1) positions leading to eligibility for board certification in a primary care specialty; and (2) positions for years of fellowship training in a primary care specialty in addition to those required for eligibility for board certification.

For the purpose of determining whether a hospital or group of hospitals has complied with the applicable minimum percentage,

the following are not considered to be graduate medical education positions: positions providing research training and for which Federal or private grant support are provided; graduate medical education positions in cancer, psychiatric, rehabilitation, eye, and ear, nose, and throat hospitals designated as specialty hospitals by the Secretary; positions held by individuals admitted to the United States under Exchange Visitors Visas; graduate medical education positions operated by the Department of Defense; and those positions in a medical specialty which the Secretary, in consultation with the Council, determines to be in relative shortage.

Council on Graduate Medical Education

The bill establishes a Council on Graduate Medical Education. The Council would be appointed by the Secretary and would be composed of nineteen private sector representatives of health care providers, health care insurers, national and specialty physician organizations, schools of medicine, and hospitals which provide graduate medical education. The Assistant Secretary for Health or his designee and the Chief Medical Director of the Veterans Administration would also be members of the Council.

Within one year after the date of enactment and every four years thereafter, the Council would be required to make recommendations to the Secretary with respect to: (1) current and future needs for physicians to practice in primary care specialties and in medical specialties which the Council determines to have a relative shortage of physicians; (2) the minimum percentages which the Secretary is required to establish for primary care residency training positions for different classes of hospitals; and (3) voluntary and cooperative efforts to be carried out by hospitals and medical and osteopathic schools to meet these minimum percentages.

State Waiver

A waiver from the minimum primary care percentage provision is permitted if the state department of health applies for the waiver and includes assurances that the hospitals in the state overall meets or exceeds the weighted average of the minimum percentages applicable to all the hospitals in the state.

Requirements for Positions to be Filled by Graduates of Approved Schools of Medicine and Osteopathy

S. 1210 provides, with two exceptions, that at least 75% of all graduate medical education positions in each specialty and subspecialty graduate medical education program in a hospital in each fiscal year must be filled by graduates of medical schools accredited by the Liaison Committee on Medical Education or schools of osteopathy accredited by the American Osteopathic Association through its Committee on Postdoctoral Training.

Positions held by foreign medical graduates who enter this country under Exchange Vistors Visas are exempted from this requirement.

This requirement will not apply in two instances: (1) GME programs which have fewer than 8 positions in a hospital in a fiscal year, if the aggregate number of positions in the hospital complies with the 75% requirement; and (2) the Secretary grants the state a

substantial disruption waiver based upon a determination that the health care services in the state would be substantially disrupted if compliance with the 75% requirement was achieved.

Applications for such a waiver must be accompanied by a detailed plan of efforts that will be undertaken to reduce dependency on foreign medical graduates.

II. BACKGROUND AND NEED FOR LEGISLATION

History of Physician Manpower Legislation

Physician manpower issues have long been an interest of the Committee. The Committee has addressed problems of inadequate physician supply and geographic and specialty distribution through a variety of programs authorized under Title VII of the Public Health Service Act. Other programs under this authority deal with similar problems for a wide range of health professions in addition to physicians. Currently authorized programs in Title VII provide Federal support for health professions education at schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, allied health, and for programs of health care administration. Title VII has provided basically two kinds of assistance—institutional support for health professions schools, student assistance in the form of loans, loan guarantees, and scholarships, and post graduate or residency training stipend support for the primary care specialties of family practice, general internal medicine and general pediatrics.

Congress initially passed legislation providing direct Federal support to schools of medicine in 1963. For nearly two decades prior to that time, Federal funding for medical education was a by-product of grants supporting biomedical research funded through the National Institutes of Health.

The legislation enacted by Congress in 1963 developed incentives to increase enrollment and to ensure the financial viability of medical schools. Congress believed that a significant expansion in physician supply was warranted in order to ensure that the future health care needs of Americans would be met. During the period from 1963 through 1970, a number of reports attested to the seriousness of this shortage. As late as 1970, the Carnegie Commission on Higher Education recommended a 50% increase in first-year enrollments at medical schools to help eliminate a perceived nationwide shortage of some 50,000 physicians.

At that time, the Congress believed the principle obstacle to a major expansion in medical school enrollments was the financial instability of many institutions. Thus, "The Comprehensive Health Manpower Training Act of 1971" was designed to increase enrollments in order to relieve institution's financial distress, by assuring a stable source of funding through capitation grants. A specified amount of money was awarded for each student it enrolled.

The combined effects of federal health manpower legislation during the years 1963–1973 stimulated a dramatic increase in the number of medical students. In 1963, when direct federal aid for medical education was first authorized, a total of 87 medical schools enrolled 32,001 students and graduated 7,336 students. By 1974–75, the number of medical schools had increased to 114, total

enrollment to 54,074 and the number of graduates to 12,714. First year enrollments at medical schools increased from 8,772 in 1963–64 to 14,159 in 1973–74.

Thus, in 1974 when the Congress began to revise the health manpower training programs the need to increase the aggregate supply of physicians was no longer the concern it had been a decade earlier. Indeed, concern that existing policies could lead to an oversupply of physicians became a subject of the legislative debate. During hearings before the Congress in 1974, the Assistant Secretary for Health of the Department of Health, Education, and Welfare estimated that by 1980 the Nation's supply of physicians would likely be adequate to meet projected requirements of physician manpower.

Instead, problems associated with the specialty and geographic maldistribution of health professionals became the focus of attention. The nation still lacked health personnel in many rural and inner-city areas. In addition, it was suggested that there were too many specialists-surgeons, neurologists, radiologists, etc., and not enough primary care physicians. Significant concerns were also expressed about the large numbers of graduates of foreign medical schools entering this country to practice medicine. The majority came to the United States for graduate medical education under an exchange visitor visa, but then remained in the U.S. and contributed to the overall supply of physicians. In 1973–74 the total number of residency positions occupied by FMGs exceeded 8,000.

The emergence of these issues lead to a debate which lasted for two years.

During that debate, a consensus was reached that the policies in effect at that time would lead to an excess supply of physicians by the 1990's and that the specialty mix of physicians in training was going to produce too few practitioners of primary care and too many specialists in the medical and surgical subspecialties.

In order to correct the problem of specialty maldistribution it was recommended that at least 50 percent of graduate physicians should be trained in the primary care specialties of internal medicine, pediatrics, and family medicine. The only real disagreement was on the mechanism by which these goals should be achieved. There were convincing arguments for either a Federal system to allocate graduate medical education positions on a regional basis, or a private/Federal effort to limit the number of GME positions and to allocate positions by specialty. Ultimately, the Congress passed the Health Professions Act of 1976 and agreed to allow the medical schools and teaching hospitals to voluntarily achieve these national goals using capitation payments to medical schools as an incentive for reforming the GME system.

To address the concern about foreign medical graduates, Title VI of the Health Professions Assistance Act of 1976 amended the Immigration and Nationality Act so that requirements for alien physicans to participate in exchange visitor programs became more restrictive.

In 1976, the Secretary of the Department of Health and Human Services (then the Department of Health, Education and Welfare) chartered a committee to study the future supply of physicans in the country, the number required to meet the health care needs of

the nation, the appropriate specialty distribution of these physicians, and to make recommendations on the basis of the committee's findings. This committee, the Graduate Medical Education National Advisory Committee (GMENAC), issued its findings in 1980 on the projected supply and requirements for physicians in the 1990s.

The establishment of GMENAC was a direct result of strong concern over the manpower issues raised during the 1974–76 health manpower debate. GMENAC estimated that by 1990, there would be a surplus of 70,000 physicians in this country and by the year 2000, this surplus would increase to 145,000.

GMENAC also made estimates of the severity of the specialty maldistribution problem, projecting an excess of most, but not all specialists. This report also estimated that there would likely be ongoing needs for more primary care physicians, rehabilitation specialists and preventive and public health experts.

Given the findings of the GMENAC report, the Committee in both 1981 and 1985 directed the renewal of the Title VII programs to the problems of oversupply and specialty mix by repealing authority for capitation grants and by focusing Federal support on programs designed to encourage physicians to enter the primary care specialties and to maintain student assistance, primarily for those with documented financial need.

Graduate Medical Education

While Congress has traditionally focused on Federal support of undergraduate medical education, it has not paid significant attention to the role the Federal government has played in graduate medical education.

After completing undergraduate medical education and receiving the professional degree, most physicians enter a graduate medical education praogram, also known as a residency training program. Graduate medical education or residency training is the term for the clinical training that interns and residents receive in the various specialties and subspecialties of medicine. This training is an integral and necessary component of the education of physicians in preparation for clinical practice. At the present time, the majority of States require at least 1 year of graduate medical education for licensure to practice medicine.

Generally, GME programs are offered by hospitals, approximately 1,200 hospitals--18% of all U.S. hospitals—participate in at least one graduate medical education program, which typically pay participating residents an annual stipend which varies with the year of residency training. In 1984–85, first-year residents receive stipends of about $20,000, while sixth-year residents receive stipends of approximately $27,000. In the course of completing a program, residents in some specialties such as preventive medicine, occupational health, and family practice may also be assigned to clinics or ambulatory centers not assocciated with a hospital.

GME training is organized by specialty (e.g., internal medicine, surgery, etc.). The distribution by specialty of the approximately 74,000 residents in 1984 is shown in Appendix I. Each of the medical specialties has established various requirements for residency

training programs and for certification as a specialist upon completion of training.

GME programs vary in length depending upon the nature of the specialty training, but generally range between 3 years, for general internal medicine and pediatrics, and 7 years, for thoracic surgery and other surgical subspecialties. For example, sataisfactory completion of three years of training in family medicine, internal medicine, or pediatrics generally qualifies a doctor to sit for examinations by the certifying boards of these specialties. Surgery requires five or more years of training depending on the subspecialty of surgery chosen. The chart in Appendix II shows the years required for training in the various specialties.

During graduate medical education, knowledge and skills acquired in medical school are expanded through increasing personal responsibility for patient care in a structured and supervised clinical education environment. Residents in hospital-based graduate medical education programs, known as housestaff officers, provide care for patients, further their own education, and teach medical school students. As residents progress through their training programs, they gain increasing autonomy and responsibility for providing patient care services, and for teaching and supervising junior housestaff officers. There were 4,811 accredited graduate programs in medical education as of December 1984.

In orded to be accredited, GME programs must be in substantial compliance with published general requirements for graduate medical education and special requirements for training in a particular specialty. Standards and requirements for graduate medical education are developed and overseen by the Accreditation Council for Graduate Medical Education (ACGME), which is composed of representatives of the American Board of Medical Specialities, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. For approval of individual training programs, the ACGME has delegated authority to an appropriate residency review committee (RRC) which consists of representatives appointed by the American Medical Association, a particular specialty board, and in some cases, a national specialty society. The ACGME monitors RRC approvals with periodic reviews of their findings.

Payment Sources for Graduate Medical Education

Graduate medical education programs are supported primarily through patient care revenues received from such payers as Medicare, Medicaid, and private health plans. For example, according to 1983–84 data on COTH member hospitals (excluding Veterans Administration hospitals), 81 percent of the funds for residency stipends and fringe benefits were derived from patient care revenues. Other sources included State appropriations earmarked for residency expenses (5 percent), Veterans Administration appropriations (2 percent), medical school/university funds (2 percent), municipal appropriations earmarked for residency expenses (1 percent), and physician fee revenues (1 percent). Foundation grants and voluntary agencies, NIH, other Federal agencies, endowment income,

and other sources of support made up the remaining 8 percent of total residency support in teaching hospitals.

Support of physician training in hospitals through patient care revenues has historically been considered appropriate since such training is produced in conjunction with patient care. Teaching hospitals have routinely included the costs of these training programs along with their other expenses in determining their total costs of producing hospital services and in setting their charges for services. Generally, these costs have also been included in patient care payments made by organizations that pay for hospital services (known as third-party payers), including Medicare, Medicaid, Blue Cross, and the commercial health insurers. Residency training in hospitals has thus been subsidized by the third-party payers, who obtain their funds for patient care payments from various sources, including employer/employee payroll taxes (Medicare), Federal and State tax revenues (Medicaid), and employer/enrollee premium payments (Blue Cross and commercial insurers).

Medicare

Since its beginning in 1965, the Medicare Program has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include salaries and fringe benefits for residents, faculty, and support staff; the cost of conference and classroom space in the hospital; any costs of additional equipment and supplies; and allocated overhead costs.

Medicare's payments to hospitals for direct medical education costs are expected to be $1.3 billion in FY 1986. Medicare also pays teaching hospitals an additional amount to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals. Medicare's payments for indirect teaching costs are expected to be $1.4 billion in FY 1986. As Medicare is the single largest payer for hospital care, it also contributes the greatest proportion of funding for graduate medical education.

Private Payers

Since teaching hospitals have historically included the costs of health professions education in their total costs and their charges for patient care, the private payers for hospitals services (including Blue Cross commercial health insurers, prepaid health plans, and private paying patients) have traditionally financed such activities through the payments they made for patient care. Thus, private payers currently pay for approximately two-thirds of direct medical education costs.

Need for Legislation

The current system of graduate medical education in this country should be reformed to meet national needs by training a greater percentage of physicans in the primary care specialties and by addressing the problem of physician oversupply. At present, payers exercise no influence over the number of training positions, the amount of the stipend associated with each position, or the distri-

bution of positions among the various medical specialties. This system has created manpower training incentives that are counter to our Nation's stated health manpower goals.

This situation is highlighted by the high cost of medical care in this country. The health care marketplace does not seem to lend itself to the classic supply and demand market theory where excess supply results in lower prices and producer income and profit. In part, this is due to the nature of our health insurance system that has traditionally insulated consumers from the cost implications of their health care service demands. In part, this is a result of the ability of physicians, at least in some areas, to generate demand for their own services and to increase the intensity of these services.

Legislation is necessary in order to set forth a coherent and flexible national health manpower policy designed to meet changing national health care needs. Legislation must be premised upon two principles.

These principles are:

First, there should be an opportunity for every graduate of an L.C.M.E.-accredited medical school to compete successfully for a position in an approved and funded GME Program. Since GME training is required for licensure in almost all States, we must be certain that every qualified graduate has the opportunity to complete his or her medical education. Recognizing the concerns about an oversupply of practicing physicians and the need to constrain health care expenditures, it is important that the number of first-year training positions offered throughout the country approximate the number of graduates of U.S. LCME-approved medical schools. Currently, there are 4,000 first year training positions in excess of the number of graduates of U.S. medical schools.

Second, there is no requirement that each graduate be able to receive training in the specialty of his or her choice. At the present, there is intense competition across the country for positions in the various specialties and in the various teaching hospitals. Individuals who choose to enter medical school must recognize from the outset that society does have a legitimate interest in the specialty distribution of physicians practicing in this country and that the individual may have to accommodate to society's needs when competing for GME training.

III. COMMITTEE CONSIDERATION

On January 31, 1985, Senator Quayle published a proposal to reform graduate medical education in the *Congressional Record* for discussion purposes. His proposal, as outlined, required that teaching hospitals comply with certain manpower-sensitive conditions in order to remain eligible for Federal financial assistance for their graduate medical education programs. The basic elements of the proposal required that:

> Hospitals offering graduate medical education positions must enter into an affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education for the purpose of ensuring a non-regulatory coordinating point for the allocation of GME positions.

A group of hospitals sharing an affiliation agreement with a medical school must offer the majority of their GME training positions in the primary care specialties of family medicine, internal medicine, pediatrics, and obstetrics/gynocology.

At least 75% of each program's trainees must be graduates of an L.C.M.E. approved medical school.

On March 25, 1985, the Senate Subcommittee on Employment and Productivity held a hearing on this proposal. Oral testimony was presented by:

Panel I—Specialty Maldistribution:

Arnold Relman, M.D., Editor, *The New England Journal of Medicine;*

Robert Heyssel, M.D., President and Director, The John Hopkins Hospital; and

Walter Daly, M.D., Dean, Indiana University School of Medicine.

Panel II—Foreign Medical Graduate:

Murry Grant, M.D. DPH, Chief Medical Adviser, U.S. General Accounting Office;

Samuel Asper, M.D., President, Educational Commission for Foreign Medical Graduates; and

Alfred Gellhorn, M.D., Director of Medical Affairs, New York State Health Department.

Panel III—Administration:

Robert Graham, M.D., Director, Health Resources and Services Administration; Public Health Service accompanied by Itzhak Jacoby, Ph.D., former Staff Director of Graduate Medical Education, National Advisory Council.

Panel IV—Academic and Professional Organizations:

David Thompson, M.D., on behalf of the American Hospital Association;

J. Robert Buchanan, M.D., on behalf of the Association of American Medical Colleges; and

Robert S. Stone, M.D., on behalf of the American Medical Association Accompanied by: Harry N. Peterson, Director, Division of Federal Legislation, American Medical Association; and Roy Schwarz, M.D., Vice President for Medical Education and Scientific Policy, American Medical Association.

This hearing was extremely valuable to the Subcommittee in exploring policy alternatives and soliciting specific recommendations for the development and consideration of a graduate medical education bill.

In addition to the hearing, a variety of meetings were held with individuals and organizational representatives interested in graduate medical education.

That process assisted in the modification of Senator Quayle's January 31 proposal and furnished the background for the introduction, on May 23, 1985, of S. 1210, "The Public Health Service Act Medical Education Amendments of 1985", by Senators Quayle and Hatch.

S. 1210 significantly modified Senator Quayle's original proposal to respond to the concerns expressed regarding the requirement for a medical school affiliation, the need for a state test for the primary care requirement, and the ability of many inner city hospi-

tals to meet the 75 percent eligibility condition for L.C.M.E. graduates. S. 1210 addressed those concerns by:

Providing for a very narrowly drawn cooperative agreement between the hospitals and a medical school. The bill clearly stated that a medical school would have the authority only to arbitrate the allocation of GME positions if the hospitals could not reach agreement on their own, and that the medical school gains no authority over the patient care services or any other operational activities of the hospital.

Allowing for a state test for the primary care requirement. This allows states with more than one medical school some flexibility in maintaining traditional differences in the characteristics of the state's medical centers.

Establishing time limited "substantial disruption waivers" from the 75 percent condition for graduates of L.C.M.E. accredited schools for hospitals whose GME programs are filled primarily by graduates of foreign medical schools, if implementation of the 75 percent requirement would result in a serious disruption of health care services. The bill required applications for waivers to be accompanied by a detailed plan for reducing dependence on foreign medical graduates.

On June 13, 1985, the Subcommittee on Employment and Productivity reported S. 1210, without amendment, to the full Senate Labor and Human Resources Committee by a vote of 6–1.

On July 10, 1985, the Committee on Labor and Human Resources conducted an executive session on S. 1210. Senator Quayle, Hatch, and Kennedy offered an amendment to S. 1210 in the nature of a substitute which was unanimously adopted by the Committee by a roll call vote of 16–0. The amended version of S. 1210 was then favorably reported out of Committee by voice vote. The amended version of S. 1210 retained many of the original elements of S. 1210, but modified it by:

(1) Making compliance with the bill voluntary and eliminating all penalties for non-compliance.

(2) Eliminating the requirement for a cooperative agreement between hospitals and medical schools. Instead hospitals can choose to meet the minimum percentage requirements for residency training positions in the primary care specialties either individually or as part of a group of hospitals.

(3) Changing the definition of primary care specialties from internal medicine, pediatrics, family medicine and obstetrics/gynecology to internal medicine, pediatrics, family medicine and such other medical specialties as determined by the Secretary in consultation with the Council on Graduate Medical Education.

(4) Modifying the requirements that the Council recommend to the Secretary a minimum percentage of training positions in the primary care specialties to a requirement that the Council recommend to the Secretary the establishment of national targets for the primary care. To achieve the national targets the Council must make recommendations to the Secretary for different minimum percentages for different classes of hospitals based on the education programs of such hospitals in FY 1985 and other such criteria the Secretary deems relevant.

(5) Exempting the specialties deemed by the Council to be in relative shortage from the minimum primary care percentage provisions of the bill.

In addition, on July 10, 1985, the full Labor and Human Resources Committee reported out a separate amendment offered by Senators Kennedy and Quayle by a vote of 13–3. This amendment is designed to provide an incentive for hospitals to comply with the provisions of S. 1210.

IV. COMMITTEE VIEWS

General

The Federal government has played an important role in addressing physician personnel issues since the early 1960's. Over the years it has become clear that we are facing problems of oversupply and overspecialization which contribute to problems related to the cost and quality of health care in this country.

Historically, reimbursement incentives and service needs have seemed to supercede educational goals in residency training programs offered by academic medical centers. The Committee believes that Federal dollars would better be spent in support of programs where education and patient care objectives are balanced.

Critics of our present GME system have suggested that Federal training funds now serve to pay for relatively inexpensive labor for hospitals. The Committee believes that public funding carries with it public responsibility.

The Committee is concerned that while our medical education institutions receive considerable Federal support, these same institutions have been relatively indifferent to addressing concerns about overspecialization and oversupply. The Committee notes that there are exceptions. The Committee is impressed by New York State's efforts to address problems of oversupply, specialty maldistribution and foreign medical graduates.

S. 1210 will establish for the first time a mechanism by which the medical education community can work to establish a national health personnel policy and a process by which this policy can be implemented. S. 1210 is crafted to allow the medical community to regulate itself and to permit progress toward explicitly measured national goals. In keeping with concern about unnecessary Federal regulation, the Committee believes the provisions of S. 1210 should be voluntary at this time.

Graduates of Foreign Medical Schools

There are at this time 13,000 FMGs (which constitutes over 18% of U.S. housestaff) training in the U.S. There are three categories of such graduates of foreign medical schools who may participate in graduate medical education programs in this country:

(1) Exchange visitors. These individuals are aliens who are undertaking residency training in this country under J-Visas (non-permanent visas) sponsored by the Education Commission for Foreign Medical Graduates (ECFMG);

(2) U.S. citizens who graduate from foreign medical schools;

(3) Alien FMGs who receive their graduate medical education in this country by virtue of having permanently immigrated to the United States.

There was extensive debate prior to passage of the Health Professions Educational Assistance Act of 1976 concerning the pending excess physician supply in this country. As a result, that Act included provisions which limited access to GME programs for alien FMGs by strengthening certain provisions of the Immigration and Nationality Act. These provisions were intended to decrease the number of foreign physicians who came to this country for GME and then stayed to enter practice. In academic year 1973–1974, more than 2,900 new exchange visitor physicians entered GME training. In sharp contrast, only 544 new exchange visitor physicians entered in 1981–82. In terms of total positions, only 1,552 exchange visitor FMGs were in graduate medical education positions in 1981–82, as compared to over 8,000 in 1973–74.

At the present time, we are faced with a different problem, namely the proliferation of "offshore" medical schools which cater to U.S. citizens who have been unsuccessful in gaining entry to a L.C.M.E. accredited medical school. The number of U.S. students studying in these schools is increasing annually, and the number entering GME programs in this country is also increasing. In 1984 just over 3,000 foreign medical graduates entered GME training programs in this country. Of these, over 1,800 were U.S. citizens, most of whom graduated from the offshore medical schools. Today U.S. FMGs account for about 55% of all FMGs training in this country.

In 1980 the GAO published the results of a study that had been conducted to assess the quality of the off-shore schools. That study raised important questions about the quality of these schools, specifically whether they provide an adequate education in the basic and clinical sciences to allow their graduates to return to this country for advanced clinical training and, ultimately, medical practice.

At the Subcommittee hearing, testimony was offered by distinguished medical educators that reinforced the conclusions of the GAO study. The witnesses felt strongly that the off-shore schools provided an inferior education and that the government should develop an effective policy to deal with this issue. In order to be accepted into an accredited GME program in this country, a FMG must achieve a minimum score on the foreign Medical Graduate Examination in the Medical Sciences administered by the ECFMG. In 1984, less than 25% of the graduates who elected to sit for the examination achieved the minimum qualifying score. There is no examination to test the clinical skills of the graduates before they are accepted in an U.S. GME program. The importance of this was emphasized by many of the witnesses at the hearing. At the same time, testimony was presented suggesting that alien foreign medical school graduates were often of higher quality and should not be denied access arbitrarily to our graduate training programs, simply because they happen not to be U.S. citizens.

In an attempt to resolve these issues, S. 1210 provides that at least 75% of the positions in each GME specialty and subspecialty program should be filled with graduates of L.C.M.E. approved med-

ical schools in the United States or Canada. The Committee believes that graduates of foreign medical schools, must not be excluded from our strong training programs, be they U.S. citizens or aliens, who have demonstrated the ability to compete favorably with graduates of our own schools. In particular, the Committee believes we should continue to provide an opportunity for a limited number of qualified foreign physicians who wish to come to the United States for advanced clinical training and then return to their own country.

However, S. 1210 would establish a policy of discouraging foreign medical school graduates from obtaining training in hospitals which attract primarily foreign graduates and are not able to attract a preponderance of U.S. graduates.

The bill does include an exception to the 75% requirement for programs which have fewer than eight positions, if all the graduate medical education positions in that hospital meet the 75% requirement. The purpose of this exception is to not harm small programs of high quality when, for example, only three out of the eight positions are held by FMGs.

A number of individuals and organizations have suggested that the limitation on FMGs could cause a grevious hardship for those inner-city public hospitals which provide care for the poor because these institutions would be unable to attract a sufficient number of graduates of U.S. schools to maintain their GME programs. The Committee believes care for the poor should be provided by GME programs of quality, whose positions are filled by at least a majority of L.C.M.E. graduates. The Committee notes that residency programs that are predominantly filled by FMGs are often of marginal quality, as evidenced by their periodic accreditation difficulties. The Committee is also aware that there are a number of inner-city public hospitals which provide excellent graduate medical education training and attract graduates of U.S. schools. These hospitals are exemplary in their ability to provide excellent medical training while providing high quality medical care for poor, medically needy citizens.

However, S. 1210 includes a provision for a Substantial Disruption Waiver for those institutions which might be most adversely affected. The Committee emphasizes that the waiver authority is time limited and that the application for a waiver must be accompanied by a plan for complying with the requirement for 75% L.C.M.E. graduate residents.

The Need for a More Balanced Mix of Specialty Trained Physicians

S. 1210 explicitly sets forth mechanisms to address the problem of physician oversupply and specialty maldistribution.

Concern over these problems has been repeatedly brought to the attention of Congress since the early 1970's. It now seems that past legislative efforts taken to resolve these problems have not been, in large measure, successful.

Thus, the Committee believes it is important to readdress these important social issues since we continue to expect a significant excess supply of physicians by the end of this decade, coupled with ongoing specialty maldistribution problems. Today, less than 45% of the total number of GME positions in this country are allocated

to the primary care specialties and only approximately 33% of physicians who complete GME training enter primary care practice. The hoped for increases in the numbers of primary care physicians have not materialized.

One thing that has changed is that we have much better data. In 1975 the Study on Surgical Services for the United States concluded that there were too many surgeons in both training and in practice. In 1980 the Graduate Medical Education National Advisory Committee (GMENAC) Report was published which projected a significant excess of physicians (70,000) by 1990 and in 2000 (145,000) and made estimates of the severity of the specialty maldistribution problem, projecting an excess of most, but not all, specialists in the same time frame. While this landmark report has been criticized, it is difficult to deny that the general projections are correct. Recent data provided by the Department of Health and Human Services Bureau of Health Manpower based on a different methodology than GMENAC, predict a physician surfeit of 35,300 in 1990 and 51,800 in 2000. While the numbers differ, the conclusion is the same—we are training too many physicians. There is also a general consensus that we are training too many subspecialists. Indeed in its Report to the President and the Congress on the Status of Health Personnel in the United States (May 1984), the Department of Health and Human Services noted that:

> The specialty distribution of health professionals continues to be an area of concern. In particular, there is concern about adequate access to the services of primary care physicians. Although the number of primary care physicians (general/family practioners, internists, and pediatricians) continued to increase in recent years, their percentage of all physicians has remained relatively constant
> * * *

Despite these projections, there is little evidence that effective steps have been taken to address the physician personnel problems highlighted by GMENAC and other studies. Thus, the Committee believes that some incentives need to be built into the system to encourage more physicians to enter training in the primary care specialties.

The provisions of S. 1210 provide an explicit solution for this public policy issue. By establishing a policy that a minimum percentage of training positions offered by a hospital individually or a group of hospitals, should be in the primary care specialties, S. 1210 will effect a shift in the output of physicians from GME programs. A larger percentage will be prepared to enter primary care practice.

The Committee wishes to emphasize that the bill does not allocate positions to each specialty and subspecialty. The Committee recognizes that there is significant variation in the capacity and capability of teaching hospitals to provide certain types of training. Thus, S. 1210 requires only that national goals regarding the percentage of positions allocated to the primary care and non-primary care specialties be established. The institutions can decide among themselves how to allocate these positions among the various specialties and subspecialties to meet the overall physician personnel

goals. Moreover, in order that certain traditionally highly specialized institutions can adjust their programs without abruptly disrupting their services, the bill permits national targets to be achieved through the setting of minimum percentages by class of hospital based on their GME programs in Fiscal Year 1985, and other criteria deemed relevant by the Secretary.

The bill specifies that the Secretary may not vary the percentages recommended by the Council by more or less than 5% points. The purpose of this provision is to prevent major swings in the minimum percentages that could seriously disrupt the planning and implementation of graduate medical education programs.

In addition, the bill excludes the following residency training positions from the primary care calculation:

(1) Positions in research training which are funded by Federal support or extramural private grants. These positions are excluded because the individuals holding those positions will enter research careers and not the practice of primary care medicine.

(2) Positions in designated specialty hospitals—cancer, psychiatric, rehabilitation, eye and ear, nose and throat hospitals. The purpose of this exclusion is to ensure that specialty hospitals are not adversely affected, and to protect the specialties of psychiatry and rehabilitation which are also considered to be shortage specialties. In addition the Committee intends that training programs in other institutions exempted from the prospective payment system also be excluded.

(3) Positions held by individuals training in this country on Exchange Visitor visas who return to their own country after their training is completed. These positions are exempted to permit this limited group of individuals to receive training in our country.

(4) Positions in the Department of Defense. These positions are excluded because the individuals who train in these positions go on to become physicians in the military which has unique needs not addressed by this bill.

State Waiver

The bill provides a state waiver from the minimum primary care percentages provision if the state as a whole can meet its weighted proportion of training slots in the primary care specialties. The Committee believes that since 50% of the residency training positions are in seven states, it is not appropriate to disturb medical education arrangements in many of the states. Moreover, this provision will allow states with more than one medical school some flexibility in maintaining traditional difference in the characteristics of the state's medical centers.

Council on Graduate Medical Education

The Committee believes that the establishment of a Council on Graduate Medical Education is particularly important because it will provide a forum to enable thorough and fair consideration of changing medical personnel needs on an ongoing basis. It is the Committee's intention that this Council serve as a mechanism for the medical education community to regulate itself and recommend appropriate changes in current training programs. The Committee expects the Council to generate meetings bringing together a broad

spectrum of the teaching community to foster cooperation among affected institutions.

It is also the Committee's intention that the Council be composed predominantly of representatives of the medical education community and that a broad cross-section of medical specialities (in particular, primary care) and institutions be represented. Also, the Committee expects the first series of appointments to the Council to include a representative of the specialty of obstetrics/gynecology since a difference of opinion exists as to whether or not this specialty should be classified as primary care.

Finally, the Committee intends that those specialists deemed by the Secretary to be in relative shortage be represented on the Council in both the initial and subsequent series of appointments to the Council.

In addition to the Council's responsibilities with regard to physician personnel needs at the graduate level, the Committee intends the Council to make recommendations relative to undergraduate medical education as it may relate to the numbers of students trained to be physicians. Accordingly, the Committee should consider the effects that a 10% reduction in undergraduate class size may have on these concerns. The Council should also consider the option of "de"-capitation incentives based on the loss of tuition to each school.

V. SEPARATE AMENDMENT

The Committee reported out a separate amendment related to the Medicare Program. This amendment is designed to provide an incentive for teaching hospitals to comply with the national manpower goals set forth in S. 1210. This is achieved by increasing Medicare direct medical education payments to complying hospitals by 10%. This amendment is budget neutral.

The Committee is strongly convinced that given the disparity between the types and numbers of physicians being trained and the health care needs of this country, it is no longer appropriate that the Federal government continue to provide "open-ended" funding for these programs which permits each hospital to determine if it wants to establish GME programs, the kind of specialty training it wants to offer, and the number of positions to offer without any consideration of the costs involved.

VI. BUDGET ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 26, 1985.

Hon. ORRIN G. HATCH,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed S. 1210, as ordered reported by the Senate Labor and Human Resources Committee on July 10, 1985. This bill would establish a Council on Graduate Medical Education which would recommend national targets for primary care residency training posi-

tions to the Secretary of the Department of Health and Human Services. Individual hospitals or groups of hospitals would be required to meet the minimum percentage set in regulations by the Secretary. The legislation would also require residency programs to have at least 75 percent of thier residency positions filled by graduates of approved schools of medicine or osteopathy. The bill contains no provisions that would adversely affect hospitals or residency programs that did not comply with the legislation.

Based on this review, it is assumed that the Council on Graduate Medical Education would cost approximately $200,000 in fiscal year 1986 and again in fiscal year 1990. Costs reflected in this estimate include salary, travel and per diem expenses for Council members, as well as any overhead costs associated with running the Council. This estimate assumes that the Council would meet four times for a total of 10 working days every four years. The estimate also assumes that the Council would not require the assistance of full-time staff. S. 1210 is not expected to significantly change outlays for graduate medical education in the Medicare, Medicaid, or Veterans Administration programs. The estimate assumes that enrollment in residency programs would not be significantly reduced by the voluntary quotas contained in S. 1210. This legislation would not significantly affect the budgets of state and local governments.

Please call if you have questions on this estimate or have your staff contact Craig Lisk on 6-2665.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

VII. REGULATORY IMPACT STATEMENT

In accordance with paragraph 5, (a) of rule XXIX of the Standing Rules of the Senate, the following statement of the regulatory impact of S. 1210 is made.

A. Estimated number of individuals and businesses regulated and their groups or classifications.—This legislation is designed to encourage teaching hospitals to take a leadership role in transforming a proportion of their residency training slots from the medical and surgical subspecialties to the primary care specialties. Approximately 1,200 (18% of all hospitals) U.S. hospitals currently conduct graduate medical education programs. However, compliance with the provisions of the bill are voluntary. Those hospitals which wished to comply with the provisions of the bill would presumably want to submit a registration application to the Secretary.

In addition, some states may wish to apply to the Secretary for a state waiver from the minimum percentage provision and/or for a substantial disruption waiver from the foreign medical graduate provision.

B. Impact of the Act on Personal Privacy.—This legislation has no impact on personal privacy.

C. Additional Paperwork, Time and Costs.—New regulations regarding the minimum percentage requirements for the primary care specialties and substantial disruption waivers are required to be promulgated. The Department of Health and Human Services will also have to maintain a registry of complying hospitals. These

will add a slight additional burden to the Department of Health and Human Services. The Committee believes that the regulatory burden of S. 1210 will not be significant.

D. Economic Impact of Such Regulation on Individuals or Business.—S. 1210 does not require the expenditure of Federal appropriations nor any funds from affected institutions. The Committee expects any expenditure of funds involved to by minimal.

VIII. ROLL CALL VOTES IN COMMITTEE

Roll call votes taken during Committee consideration of this legislation are as follows:

1. Quayle motion for the Subcommittee on Employment and Productivity to order reported to the full Labor and Human Resources Committee, S. 1210, without amendment.

Motion agreed to 6 yeas, 1 nay.

YEAS	NAY
Hatch	Grassley
Quayle	
Hawkins	
Simon	
Pell	
Dodd	

2. Hatch motion to order reported S. 1210, as amended, favorably to the Senate.

Motion agreed to 16 yeas, 0 nays.

YEAS	NAY
Hatch	
Stafford	
Quayle	
Nickles	
Hawkins	
Thurmond	
Weicker	
Wallop	
Grassley	
Kennedy	
Pell	
Metzenbaum	
Matsunaga	
Dodd	
Simon	
Kerry	

IX. SECTION-BY-SECTION SUMMARY

Section 1 cites the title of the bill as the Public Health Service Act Medical Education Amendments of 1985.

Reference

Section 2 provides that the bill amends Title VII of the Public Health Service Act by adding Part H.

Definitions

Section 799. This section defines the terms "Council", "graduate medical education", "primary care specialty", and "minimum percentage" for the purposes of this Act.

Teaching Hospital Registry

Section 799A. This section states that a hospital may register with the Secretary of the Department of Health and Human Services by submitting an application containing assurances that for that fiscal year: (1) the hospital, individually or as part of a group of hospitals, will comply with the minimum percentage of residency positions in the primary care specialties for its class of hospitals established by the Secretary under Section 799B; and (2) the hospital will comply with the provisions of Section 799C limiting the number of graduate medical education positions filled by graduates of foreign medical schools.

Establishment of Minimum Percentages for Primary Care Specialty Positions

Section 799B sets forth the procedure by which national targets for primary care specialty positions will be established.

Subsection (a)(1) provides that within one year of enactment of this Act, the Council shall make recommendations to the Secretary with respect to the establishment of national targets for primary care residency positions for a four fiscal year period. To achieve the targets, the Council shall make recommendations to the Secretary for the establishment of different minimum percentages for different classes of hospitals, based on the graduate medical education positions of such hospitals in fiscal year 1985 and other criteria the Secretary deems relevant.

Subsection (a)(2) provides that within six months after receiving the Council's recommendations, the Secretary must by regualtion establish the minimum percentages recommended by the Council or shall remand such recommendations to the Council.

Subsection (a)(3) provides that the minimum percentages established under this Act shall take effect no later than 24 months after the date on which such percentages are established.

Subsection (b)(1) provides that within four years after submitting recommendations under Subsection (a)(1) and every four years thereafter, the Council must submit recommendations to the Secretary with respect to the establishment of minimum percentages for a four fiscal year period.

Subsection (b)(2) provides that within six months after receiving recommendations for the Council under Subsection (b)(1), the Secretary shall be regulation establish minimum percentages for a four-fiscal year period or shall remand such recommendations to the Council.

Subsection (c)(1) provides that for the purposes of determining whether a hospital or a group of hospitals has complied with the applicable minimum percentage for a fiscal year, the positions that will be considered to be positions in the primary care specialties are those leading to eligibility for board certification in a primary

care specialty and fellowship training positions in a primary care specialty.

Subsection (c)(2) provides that for the purpose of determining whether a hospital or a group of hospitals has complied with the applicable minimum percentage for a fiscal year, types of positions not considered to be graduate medical education positions are those: providing research training and for which Federal or extramural private grants are provided; in cancer, psychiatric, rehabilitation, eye, ear, nose and throat hospitals designated as specialty hospitals by the Secretary; held by non-immigrant aliens admitted to the United States under exchange visitor visas; operated by the Department of Defense; and those in a medical specialty which has a relative shortage of physicians, as determined by the Secretary after consultation with the Council.

Subsection (d)(1) provides that for any fiscal year, the Secretary may waive the applicability of the applicable minimum percentage to a hospital or group of hospitals if the State departmnt of health applies to the Secretary for the waiver and the waiver application contains assurances that the percentage of graduate medical education positions in the state as a whole equals or exceeds the State minimum percentage.

Subsection (d) (2) provides that for the purpose of subsection (d) (1), the term state minimum percentage means the weighted average of the minimum percentages applicable to all the hospitals in a state.

Requirements for Positions To Be Filled, by Graduates of Approved Schools of Medicine and Osteopathy

Section 799C provides that 75% of all residency training positions in each specialty and subspecialty graduate medical education program must be filled by graduates of L.C.M.E. accredited medical schools or schools of osteopathy accredited by the American Osteopathic Association through its Committee on Postdoctoral Training.

Subsection (b) provides that notwithstanding subsection (a) Subsection (a) not more than 25% of all GME positions in each specialty and subspecialty GME program in any hospital in any fiscal year may be held by individuals who are not graduates to accredited schools and who are admitted to the United States under exchange visitors visas. It also provides that not more than 25% of the positions can be held by U.S. citizens and aliens, admitted to the United States under provisions of the Immigration and Nationality Act other than exchange visitor visas, who are not graduates of accredited schools.

Subsection (c) provides that the provisions of subsections (a) and (b) will not apply to GME programs which have fewer than eight positions in a hospital in any fiscal year, if, as determined in the aggregate, graduate medical education positions in such hospitals in such fiscal year comply with subsections (a) and (b).

Subsection (d) provides that the Secretary may waive the provisions of subsections (a) and (b) with respect to a particular specialty or subspecialty graduate medical education program in a hospital in a State for a fiscal year if: (1) the State department of health applies to the Secretary for such a waiver; and (2) and the application contains information as to the problems the State anticipates

compliance with subsections (a) and (b) would cause in the delivery of health care services and what efforts will be undertaken to reduce dependence on foreign medical graduates.

Subsection (d) (3) provides that the Secretary may grant such a waiver upon a determination that the implementation of subsections (a) and (b) would result into a substantial disruption of health care services in the State by individuals holding GME positions in the State.

Council on Graduate Medical Education

Section 799D provides for the establishment of the Council on graduate Medical Education and the appointment and composition of the members of the Council.

It provides that the Council must make recommendations to the Secretary within one year of the date of enactment of the bill and every four years thereafter with respect to: (1) current and future needs for physicians to practice in primary care specialties and in medical specialties which the Council determines to have a relative shortage of physicians; and (2) the minimum percentages which the Secretary should establish under Section 799B; and voluntary and cooperative efforts to be carried out by hospitals, schools of medicine, and schools of osteopathy as may be appropriate to achieve the purposes of the bill.

Effective Dates

Section 799D (b) provides that the provisions of this Act will take effect 42 months after the date of enactment except that section 799B and 799D will become effective on the date of enactment of this Act.

APPENDIX I

NUMBER OF RESIDENTS RANK ORDERED BY SPECIALTY, 1984

Specialty	Number of residents	Percent of total	Cumulative
1. Internal Medicine	18,167	24.4	24.4
2. Surgery	8,189	11.0	35.4
3. Family Practice	7,408	9.9	45.3
4. Pediatrics	6,025	8.1	53.4
5. OB/GYN	4,615	6.2	59.6
6. Psychiatry	4,558	6.1	65.7
7. Anesthesiology	3,894	5.2	70.9
8. Radiology, Diagnostic	3,176	4.3	75.2
9. Orthopedic Surgery	2,842	3.8	79.0
10. Pathology	2,462	3.3	82.3
11. Opthalmology	1,569	2.1	84.4
12. Transitional Year [1]	1,480	2.0	86.4
13. Neurology	1,408	1.9	88.3
14. Emergency Medicine	1,108	1.5	89.8
15. Otolaryngology	1,047	1.4	91.2
16. Urology	1,043	1.4	92.6
17. Dermatology	779	1.0	93.6
18. Physical Medicine and Rehabilitation	712	1.0	94.6
19. Neurological Surgery	695	0.9	95.5
20. Child Psychiatry	520	.7	96.2
21. Radiology, Therapeutic	519	.7	96.9
22. Plastic Surgery	430	.6	97.5
23. Thoracic Surgery	292	.4	97.9
24. Allergy and Immunology	258	.3	98.2
25. Neonatal-Perinatal Medicine	216	.3	98.5
26. Nuclear Medicine	203	.3	98.8
27. Preventive Medicine General	199	.3	99.1
28. Pediatric Cardology	138	.2	99.3
29. Radiology, Diagnostic (Nuclear)	88	.1	99.4
30. Occupational Medicine	87	.1	99.5
31. Combined General Preventive Medicine/Public Health	58	.1	99.6
32. Aerospace Medicine	54	.1	99.7
33. Neuropathology	44	.1	99.8
34. Colon and Rectal Surgery	41	.1	99.9
35. Forensic Pathology	35	.....	.....
36. Blood Banking	34	.....	.....
37. Pediatric Surgery	27	.....	.....
38. Vascular Surgery	27	.....	.....
39. Public Health	25	.....	.....
40. Dermatopathology	23	.....	.....
Total	74,495	.....	.....

[1] Transitional year programs provide a 12-month curriculum to residents who desire or are required to have experience in several medical clinical disciplines prior to undertaking further training in a single specialty.

Source: "1985–1986 Directory of Residency Training Programs" American Medical Association, 1985.

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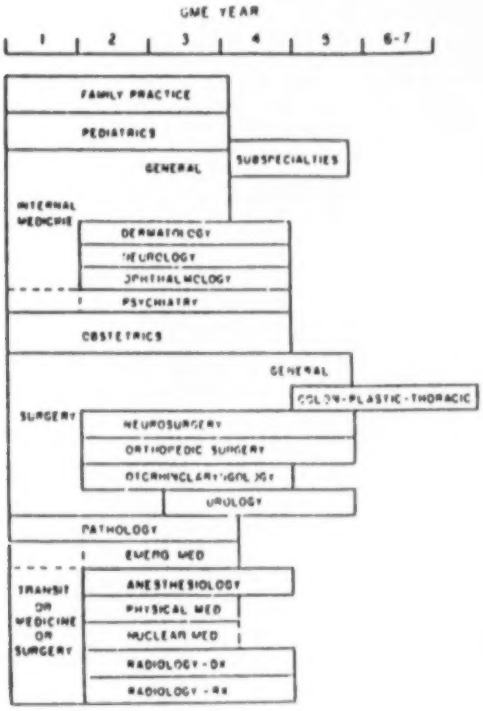
APPENDIX II

Years Required for Training in Various Specialties



Source: NRMP Directory. National Resident Matching Program. Evanston, ILL. Oct. 1984., p. 18.

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